

Section 5199 Appendix B – Alternate Respirator Medical Evaluation

Questionnaire for Filtering Facepiece Respirators Used for Protection Against Infectious Aerosols

To the employer: Answers to questions in Section 1, and to question 6 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read and understand this (circle one): Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: _____

Name: _____

Job Title: _____

Your age (to nearest year): _____

Sex (circle one): Male Female

Height: _____ ft. _____ in. Weight: _____ lbs.

Phone number where you can be reached (include the Area Code): (_____) _____

The best time to phone you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire : Yes No

Check the type of respirator you will use (you can check more than one category):

N, R, or P disposable respirator (filter-mask, non-cartridge type only).

Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA). **(fill in type here)**

Have you worn a respirator (circle one): Yes No

If "yes," what type(s):

Part A. Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Have you ever had any of the following conditions?

Allergic reactions that interfere with your breathing: Yes No

What did you react to? _____

Claustrophobia (fear of closed-in places) Yes No

2. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath when walking fast on level ground or Coughing up blood in the last month: Yes No

walking up a slight hill or incline: Yes No Wheezing that interferes with your job: Yes No

Have to stop for breath when walking at your Chest pain when you breathe deeply: Yes No

own pace on level ground: Yes No Any other symptoms that you think

Shortness of breath that interferes with your job: Yes No may be related to lung problems: Yes No

Coughing that produces phlegm (thick sputum): Yes No

3. Do you currently have any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest:	Yes	No	Pain or tightness in your chest that interferes with your job:	Yes	No
Pain or tightness in your chest during physical activity:	Yes	No	Any other symptoms that you think may be related to heart or circulation problems:	Yes	No

4. Do you currently take medication for any of the following problems?

Breathing or lung problems:	Yes	No
Heart trouble:	Yes	No
Nose, throat or sinuses	Yes	No
Are your problems under control with these medications?	Yes	No

5. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check the following space and go to question 6:)

Skin allergies or rashes:	Yes	No	General weakness or fatigue:	Yes	No
Anxiety:	Yes	No			
Any other problem that interferes with your use of a respirator:					
Yes	No				

6. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:

Yes	No
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Employee Signature

Date

PLHCP Signature

Date

